

CONFIDENTIAL COMMUNICATION REQUEST

File Number: _____

You may ask the Department of Health Services to contact you at an address or telephone number which is different from that currently in your Cancer Detection Section records, or to contact you only by a limited method (such as only by mail or only by telephone). To request this, mail this completed form to:

*Cancer Detection Section
Attention: HIPAA Manager
MS-7203, P.O. Box 997413
Sacramento, CA 95899-7413*

INDIVIDUAL INFORMATION			
LAST NAME		FIRST NAME	MIDDLE INITIAL
CURRENT ADDRESS		CITY/STATE	ZIP CODE
Cancer Detection Programs: Every Woman Counts RECIPIENT ID NUMBER*		DATE OF BIRTH	SOCIAL SECURITY NUMBER*
DAYTIME PHONE NUMBER (____) _____	ALTERNATE PHONE NUMBER (____) _____	BEST TIME TO REACH YOU	EMAIL ADDRESS

*We use these numbers to make sure information goes only to appropriate persons.

If you don't supply at least one of the numbers, we will be unable to honor your request. You can get your Recipient ID Number from the place where you received medical services paid for by the Cancer Detection Programs: Every Woman Counts.

I REQUEST THAT THE CANCER DETECTION SECTION CONTACT ME AT A DIFFERENT ADDRESS AND/OR A DIFFERENT TELEPHONE NUMBER THAN THAT LISTED ABOVE BECAUSE CONTACTING ME AT MY CURRENT ADDRESS AND/OR TELEPHONE NUMBER IS A SAFETY ISSUE FOR ME.	
ALTERNATE STREET ADDRESS OR POST OFFICE BOX TO CONTACT ME	
CITY, STATE	ZIP CODE
ALTERNATE TELEPHONE NUMBER TO CONTACT ME (____)	
YOU MAY ALSO REQUEST THAT THE CANCER DETECTION SECTION LIMIT THE WAY IT CONTACTS YOU.	

I REQUEST THAT THE CANCER DETECTION SECTION CONTACT ME

☐ ONLY BY TELEPHONE ☐ ONLY BY MAIL (PLEASE CHECK ONE)

IDENTIFYING INFORMATION

☐ COPY OF PHOTO IDENTIFICATION ATTACHED

ACCEPTABLE IDENTIFICATION IS A CALIFORNIA DRIVER'S LICENSE, CALIFORNIA DMV IDENTIFICATION CARD, PASSPORT, MATRICULA CONSULAR OR STATE OR FEDERAL EMPLOYEE ID CARD.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

BENEFICIARY SIGNATURE _____ DATE _____

☐ **IF NO PHOTO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.**

NOTARIZED BY _____ ON _____ (DATE)

NOTARY PUBLIC NUMBER _____

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC

☐ IF THE PHOTO IDENTIFICATION DOESN'T SHOW THE CURRENT ADDRESS ON PAGE 1 OF THIS FORM, PLEASE PROVIDE A PHOTOCOPY OF ONE OF THE FOLLOWING TO CONFIRM YOUR CURRENT ADDRESS: UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.

NOTE: ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH INFORMATION IS SUBJECT TO LEGAL PENALTIES.

DHS is committed to protecting the information you provide us. To prevent unauthorized access or disclosure, to maintain data accuracy, and to ensure the appropriate use of the information, DHS has in place appropriate physical and managerial procedures to safeguard the information we collect.